Application for Basic Coverage

Use this form if you are requesting a change from employee only to family coverage or from family to employee only coverage.

NOTE: **Do not delay submitting this form by the deadline because you experience a delay in obtaining information or documents.**

Employee Information – Please complete pages 1-3

Name (Last, First, Middle Initial) _____

Employee ID # _____

Social Security # _____

Birth date _____

Address _____

City _____ State _____ Zip _____

Work phone ( ) _____

Home phone ( ) _____

Instructions: *Please refer to Your Employee Benefits booklet prior to completing this form: ,http://mn.gov/mmb/images/2015-Your-EE-Benefits.pdf . All information is required. Please complete the form and sign and date page 3. All pages must be received at SEGIP by the deadline.*

Medical Coverage - To find a medical clinic number go to: **http://mn.gov/mmb/segip/medical-dental/current-employees/choose_your_clinic/ - Blue Cross, HealthPartners, PreferredOne** (If already covered under SEGIP medical plan can't be changed mid-year.)

Medical Plan: _____ Clinic number _____

☐ Employee –only coverage
Do you have Medicare? ☐ Yes* ☐ No

☐ Family coverage (complete dependent information below)
Do any of your dependent(s) have Medicare? ☐ Yes* ☐ No

*If yes, complete Part C on the back of this form.

Dental Coverage – Delta Dental or Health Partners Dental Plan (If already covered under SEGIP, dental plan can't be changed mid-year)

Plan choice _____

☐ Employee-only coverage ☐ Family coverage (complete dependent information below)

Dependent Information

Please fill out completely so the change is not delayed.

Use additional form if necessary. SEGIP needs all information in order to make changes. **Please provide SEGIP with this form by the applicable deadline. A separate request for documentation will be automatically sent. If enrolling a spouse or dependent(s) you will be asked for proof of spouse/dependent eligibility. To see a list of required documents go to our web page at http://mn.gov/mmb/images/Dep-Elig-Chart.pdf .**

Name of person to add/drop from Coverage:	Birth date (mm/dd/yy)	Sex	Address	**Social Security #	Health Clinic #

*You must complete Part B on page 2 to verify spouse eligibility for health coverage.

**Do not delay sending the form while waiting to receive a social security number. Please write "Applied for" and send the form to SEGIP by the deadline.

Part A. Changes in coverage

To make changes in your insurance coverage outside of the annual open enrollment period, there must be a "life event" consistent with your request. This change must have occurred within the last 30 days to add coverage and the last 60 days to cancel coverage. Please check the appropriate box.

Add family coverage because of:

☐ Marriage Date _____

☐ Birth/adoption of a child Date _____

☐ Spouse/dependent lost employment/other group insurance coverage Date _____

☐ Change in employment status that affects insurance for: Date of change _____

☐ You ☐ Spouse ☐ Child Type of change: _____

☐ Other (please explain) _____

Cancel family coverage because of:

☐ Your divorce (Provide relevant pages from divorce decree) Date _____

☐ Death of last eligible dependent Date _____

☐ Change in child's eligibility: Date _____

☐ Medical and Dental- Child has reached his/her 26th birthday. Birth date _____

☐ Child is under age 26 and has enrolled in other employer-sponsored coverage within the past 60 days:

☐ Drop from **Medical** Coverage/Date:_____ ☐ Drop from **Dental** Coverage/Date:_____

☐ Change in employment status that affects insurance for: Effective Date _____

☐ You ☐ Spouse Specify type of change: _____

☐ Other (please explain) _____

SEGIP will request documentation to verify event and date, including a copy of employment/coverage termination notice from spouse or dependent employer before we can make a change. Do not delay submitting the Basic Application. SEGIP staff will work with you to follow up on the documentation.

Part B. Spouse eligibility

Please answer the following for SEGIP to determine whether your spouse is eligible for coverage your health insurance.

1. Is your spouse employed full-time by an employer with 100 or more employees? Yes No
2. Is your spouse eligible to receive health insurance from his/her employer? Yes No
3. Has your spouse chosen to receive from their employer
   a. Cash instead of health insurance, or Yes No
   b. Credit towards the purchase of some other benefit instead of health insurance, or Yes No
   c. Cash and a health insurance plan with a deductible of $750 or more, this includes a high deductible plan Yes No

4a. Is your spouse eligible for insurance benefits as an employee of the State of Minnesota or another organization participating in the State Employee Group Insurance Plan (SEGIP) ? Yes No

4b. If yes, has coverage been waived or will coverage be waived? Yes No

- Your spouse is NOT eligible for coverage on your health coverage if you answered "Yes" to questions, 1, 2 and 3.
- Your spouse is NOT eligible if you answered "Yes" to question 4a and "No" to question 4b.

NOTE: If your spouse has a high deductible health plan (HDHP) and an HSA, HSA rules prohibit your spouse from certain SEGIP coverage. Please contact your spouse's employer to understand these eligibility rules. If your spouse has a health savings account (HSA), you cannot have a general purpose MDEA but rather a limited purpose MDEA. This Limited MDEA allows your spouse to maintain HSA eligibility.

I understand I must notify the SEGIP if my spouse's eligibility for insurance changes.

Part C. Medicare Information

Name of Medicare-enrolled member(s):* _____

Does the covered member have Medicare Hospital Coverage (Part A)? ☐ Yes ☐ No

If yes, effective date _____ Medicare #_____

Does the covered member have Medicare Hospital Coverage (Part B)? ☐ Yes ☐ No

If yes, effective date _____ Medicare #_____

Reason for Medicare coverage: (check one): ☐ age ☐ disability ☐ end stage renal disease

Part D. Important Plan Information and Employee Authorization

If there is a change in my spouse or dependent's eligibility for insurance, I understand that it is my responsibility to notify SEGIP in writing of such a change.

Statement of Fraud or Intentional Misrepresentation

Each Member must notify the Plan Administrator immediately of the date the Member knew or should have known that information either:

1. Contained in the enrollment form pertaining to the Member or any individual related to the Member receiving or seeking benefits under the Plan, or
2. Related to a claim for benefits

is or has become incorrect due to an affirmative statement of information, an omission of information, or a change in circumstances.

The Plan Administrator may rescind or cancel the coverage of a Member and/or each individual enrolled in the Plan under the Member upon thirty (30) days prior written notice if the Plan Administrator determines that the Member or individual made an intentional misrepresentation of material fact or was involved in fraud concerning any matter relating to eligibility for coverage or claim for benefits under the Plan.

Coverage for each individual identified in a Notice of Rescission of Coverage will be rescinded as of the date specified in the Notice of Rescission of Coverage, which may be to the effective date of individual's coverage. The Member and any individual involved in the misrepresentation or fraud may be liable for all claims paid by the Plan on behalf of such individuals.

By signing this form, I am attesting that my spouse/dependents are eligible for coverage according to the eligibility rules as defined in the Summary of Benefits or applicable labor agreement or compensation plan. I understand the attempted or actual enrollment of ineligible dependents may be considered fraud or intentional misrepresentation of a material fact. I further understand, that both myself and any individual involved in fraud or intentional misrepresentation of a material fact, may be liable for all claims paid by the Plan on behalf of such individuals and may be subject to employment discipline, up to and including discharge and may also be subject to criminal penalties.

I am applying for coverage (or changes in coverage) in the Minnesota State Employee Group Insurance Program, and Health and Dental Premium Account, subject to approval of my eligibility. I authorize my employer to disclose the foregoing information to the insurance carrier(s) indicated, for use in determining my eligibility and in processing my application. This authorization is valid until revoked by operation of law. If paid through the State of Minnesota central payroll system, I authorize payroll deductions for my share of the premiums on a before-tax basis.

To have premiums taken on a post-tax basis, contact SEGIP at 651-355-0100.

Your signature _____

Date _____

Please note, your completed forms must be RECEIVED at MMB SEGIP offices by the deadline date. Do not delay submitting the form because you are waiting for any documentation or information.

You may fax forms to our office at 651-296-5445, or scan and email to segip.mmb@state.mn.us. If you choose to mail your form send it to:

SEGIP
400 Centennial
658 Cedar Street
Saint Paul, MN 55155
Phone 651-355-0100
Fax 651-296-5445

Minnesota Management & Budget

NOTICE OF COLLECTION OF PRIVATE DATA

Minnesota Management & Budget (MMB) administers the State Employee Group Insurance Program (SEGIP). This notice explains why we may request information (data) about you, your spouse, and dependents, how we will use it, who will see it, and your obligation to provide that information.

What information will we use?
We will use the information you provide us at this time, as well as information previously provided us, about yourself, your spouse, or dependent(s). If you provide any information about that is not necessary, we will not use it for any purpose.

SEMA4, the information system used to administer employee benefits, contains required information fields that may not be necessary for us to process your request. We do not need the gender or marital status for your beneficiary designation, so you may enter "unknown" in these fields. We only need your dependent's date of death to process a death benefit claim or to discontinue the dependent's coverage due to his or her death. Student status and disability status are needed only to determine eligibility for insurance continuation for your dependent. We need the social security numbers and birth dates of your spouse and dependent to offer insurance continuation, process a death benefit, to ensure we are matching them to the correct insurance benefit transaction and to comply with federal Medicare coordination laws.

Why we ask you for this information?
We ask for this information so that we can successfully administer SEGIP. This information is used to process your request to add or change coverage for yourself, your spouse, dependents or beneficiary. The requested information helps us to determine eligibility, to identify you and your spouse, and dependents, and to contact you or your spouse, and dependents. The information is also used to develop new programs, ensure current programs effectively and efficiently meet member needs, and to comply with federal and state law and rules. We may ask for information about you, your spouse or dependents that we have already collected, including all or part of your social security number, in order to ensure we are matching you to the correct insurance benefit transaction.

Do you have to answer the questions we ask?
You may not be legally required to provide any of the information requested.

What will happen if you do not answer the questions we ask?
If you do not answer these questions, the insurance benefit transaction you requested for you or your spouse, dependent or beneficiary or other insurance benefit transaction may be delayed or denied.

Who else may see this information about you and your spouse and dependents?
We may give data about you and your spouse, and dependents to the insurance carrier you have chosen, SEGIP's other representatives, vendors and actuary; the Legislative Auditor; the Department of Health; the Department of Commerce; and any law enforcement agency or other agency with the legal authority to the information; and anyone authorized by a court order. In addition, the parents of a minor may see information on the minor unless there is a law, court order, or other legally binding instrument that blocks the parent from that information.

How else may this information be used?
We can use or release this information only as stated in this notice unless you give us your written permission to release the information for another purpose or to release it to another individual or entity. The information may also be used for another purpose if Congress or the Minnesota Legislature passes a law allowing or requiring us to release the information or to use it for another purpose.